Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth St., Suite. 4T20
Atlanta, Georgia 30303-8909

April 3, 2008

Dr. Steven Oxley, Director
John Umstead Hospital
1003 12th Street
Butner, NC 27509

RE: CMS Certification Number (CCN): 34-4004

Dear Dr. Oxley:

Institutions accredited as hospitals by the Joint Commission (JC) are deemed to meet all of the Medicare Conditions of Participation for hospitals, with the exception of utilization review and the special staffing and medical record requirements for psychiatric hospitals. Section 1864 of the Social Security Act authorizes the Secretary of Health and Human Services to conduct surveys of accredited hospitals participating in the Medicare program if there are "substantial allegations" indicating serious deficiencies that could potentially affect the health and safety of patients.

A survey was conducted at John Umstead Hospital on November 27-30, 2007, with immediate jeopardy being identified. Copies of the deficiencies cited during the November 27-30, 2007 survey were sent to you previously and a follow up to these deficiencies and a full survey was conducted by the North Carolina State Survey Agency on December 20-21, 2007, determined that the conditions that led to the determination of immediate jeopardy were removed however; the facility did not meet the following conditions of participation:

42 CFR 482.12 Governing Body
42 CFR.23 Nursing Services
42 CFR 482.41 Physical Environment

As a result of this survey, your hospital was termination was set for March 30, 2008. A follow-up to this full survey was conducted on March 13, 2008. This survey determined that the conditions that led to the determination of immediate jeopardy were removed however; the facility does not meet the following conditions of participation:

42 CFR 482.12 Governing Body
42 CFR 482. 13 Patients Rights
42 CFR 482.41 Physical Environment

When a hospital, regardless of its JCAHO accreditation status, is found to be out of compliance with one or more Conditions of Participation, a determination must be made that the facility no longer meets the requirements for participation as a provider of services in the Medicare program. Such a determination has been made in the case of John Umstead and, accordingly, the Medicare provider agreement between John Umstead and the Secretary of the Department of Health and Human Services is being terminated. This termination will be effective **April 25, 2008**.

The Medicare program will not make payment for inpatient hospital services furnished to patients who are admitted on or after **April 25, 2008**. For patients admitted prior to **April 25, 2008**, payment may continue to be made for a maximum of 30 days for inpatient hospital services furnished on or after **April 25, 2008**. You should submit as soon as possible, a list of names and Medicare claim numbers of beneficiaries in your hospital on **April 25, 2008**, to your fiscal intermediary to facilitate payment for these individuals.

We will publish a public notice in a local newspaper prior to the termination date. Termination can only be averted by correction of these deficiencies by **April 25, 2008**. Should we not hear from you, we will assume that the situation has not been corrected. **If you believe that compliance has been achieved, you should notify CMS and the North Carolina State Survey Agency in writing on or before April 13, 2008, describing in detail the specific corrective measures taken to resolve these problems and include acceptable completion dates.** ***An acceptable plan of correction must contain the following elements:***

1) The plan of correcting the specific deficiency cited. The plan should address the processes that lead to the deficiency cited;
2) The procedure for implementing the acceptable plan of correction for the specific deficiency cited;
3) The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;
4) The title of the person responsible for implementing the acceptable plan of correction.

If your "credible allegation" of compliance is accepted, the State Survey Agency will be authorized to conduct a resurvey to determine if these conditions of have been corrected. Please be advised, however, that failure to correct these conditions that will result in your hospital's termination under Medicare, effective **April 25, 2008**. If the Centers for Medicare & Medicaid Services determines that the reasons for termination remain, the effective date of the termination remains **April 25, 2008**, and you will be so informed in writing. If corrections have been made, the termination procedures will be halted, and you will be notified in writing.

If you believe that this termination decision is incorrect, you may request a hearing before an Administrative Law Judge (ALJ) at the Departmental Appeals Board, Department of Health and Human Services. Procedures governing this process are set out in section 42 CFR 498.40, et seq. To be effective, a written request for a hearing must be filed not later than 60 days after the date you receive this letter. Such a request may be made to the following address:

Sandra M. Pace
Associate Regional Administrator
Centers for Medicare & Medicaid Services
61 Forsyth Street, SW, Suite 4T20
Atlanta, Georgia 30303-8909

We will forward your request to the Departmental Appeals Board. The request for a hearing should state why CMS's decision is considered incorrect, and should be accompanied by any evidence and arguments you may wish to bring to the attention of the Department of Health and Human Services. Evidence and arguments may be presented at the hearing, and you may be represented by legal counsel.

If there are any questions, please contact Janetta Booker at (404) 562-7343.

Sincerely,

for

Sandra M. Pace
Associate Regional Administrator
Division of Survey & Certification

Enclosure
CMS 2567

cc: JCAHO
State Agency

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344004	A. BUILDING _____ B. WING _____	R 03/14/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHN UMSTEAD HOSP	1003 12TH ST BUTNER, NC 27509

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 043	482.12 GOVERNING BODY The hospital must have an effective governing body legally responsible for the conduct of the hospital as an institution. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body. This CONDITION is not met as evidenced by: Based on open record review, observation, staff and physician interview, hospital policy review, corrective action plan review and performance improvement data review, the hospital's leadership failed to ensure systems were in place to protect the rights of patients and maintain safety as evidenced by failing to ensure a safe environment that was free of hazards, failing to ensure body alarms were worn by staff on duty according to policy, failing to monitor the utilization of body alarms and failing to maintain privacy. The hospital's leadership failed to arrange and maintain the facilities to ensure the safety of patients. The findings include: A) The hospital failed to maintain a safe environment by placing a patient in an environment that was not free of hazards for 1 of 14 current patients sampled (#3) – cross refer to 482.13(c)(2) Patients' Rights, Standard, Tag A0144 B) The hospital failed to ensure body alarms were worn by staff on duty according to policy for 3 of 3 staff members (Staff #3, 4 and 5) and 3 of	A 043		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 043	Continued From page 1 7 staff members (Staff #2, 6 and 7) assigned to two Adult Admissions Unit (AAU) wards (wards 362 and 233) - cross refer to 482.13(c)(2) Patients' Rights, Standard, Tag A0144 C) Based on review of facility policies and procedures, corrective action plans, performance improvement data and staff interview facility leadership staff failed to monitor staff use of body alarms. - cross refer to 482.21(a)(2) QAPI, Standard, Tag A0267 D) The hospital failed to maintain privacy by failing to obscure the view from an external window into the patient's bedroom for 1 of 14 current patients sampled (#18). - cross refer to 482.13(c)(1) Patients' Rights, Standard, Tag A0143 E) The hospital failed to maintain the environment ensuring the safety and well being of patients as referenced in the Life Safety survey completed 12/20/2007. -Cross-refer to 482.41(a) Physical Environment Standard Tag A 701 F) The hospital failed to ensure expired supplies were not available for patient use, supplies and patient nourishments were stored appropriately, refrigerator temperatures were monitored, terminal cleaning was performed upon patient discharge and quality linen was available for patient use.	A 043		

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A 043	Continued From page 2 ~Cross-refer to 482.41(c)(2) Physical Environment Standard Tag A 724	A 043		
(A 115)	482.13 PATIENT RIGHTS A hospital must protect and promote the rights of each patient This CONDITION is not met as evidenced by: Based on open record review, observation, staff and physician interview, hospital policy review, corrective action plan review and performance improvement data review, the hospital failed to protect the rights of patients and maintain safety as evidenced by failing to ensure a safe environment that was free of hazards, failing to ensure body alarms were worn by staff on duty according to policy, failing to monitor the utilization of body alarms and failing to maintain privacy. Findings include: A) The hospital failed to maintain a safe environment by placing a patient in an environment that was not free of hazards for 1 of 14 current patients sampled (#3) ~ cross refer to 482.13(c)(2) Patients' Rights, Standard, Tag A0144 B) The hospital failed to ensure body alarms were worn by staff on duty according to policy for 3 of 3 staff members (Staff #3, 4 and 5) and 3 of 7 staff members (Staff #2, 6 and 7) assigned to	(A 115)		

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(A 115)	Continued From page 3 two Adult Admissions Unit (AAU) wards (wards 362 and 233). - cross refer to 482.13(c)(2) Patients' Rights, Standard, Tag A0144 C) Based on review of facility policies and procedures, corrective action plans, performance improvement data and staff interview facility leadership staff failed to monitor staff use of body alarms. - cross refer to 482.21(a)(2) QAPI, Standard, Tag A0267 D) The hospital failed to maintain privacy by failing to obscure the view from an external window into the patient's bedroom for 1 of 14 current patients sampled (#18) - cross refer to 482.13(c)(1) Patients' Rights, Standard, Tag A0143	(A 115)		
A 143	482.13(c)(1) PATIENT RIGHTS: PERSONAL PRIVACY The patient has the right to personal privacy. This STANDARD is not met as evidenced by: Based on observation and staff interview, the hospital failed to maintain privacy by failing to obscure the view from an external window into the patient's bedroom for 1 of 14 current patients sampled (#18). Findings include: Observation during tour on 03/14/2008 at 1030 of room #8, ward 233, AAU (Adult Admissions Unit)	A 143		1/22/08

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A 143	Continued From page 4 revealed a patient room with two beds. There was a window that measured 72 inches wide by approximately 60 inches long that was located on an exterior wall on ground level. Further observation revealed no window covering for privacy. Further observation revealed the window was facing a road and parking lot that was approximately 50 to 75 yards away from the open window in the patient's room. Interview during the tour with a staff member revealed that Patient #18 was currently admitted to room #8. The interview revealed that the patient had been admitted to the room on 03/12/2008 (two days prior). The staff member stated that the curtains had not been replaced after another patient had removed the aluminum track that held the curtains on 03/05/2008. The staff member revealed that the patient could be observed through the window especially at night with the lights on in the patient's room. The staff member confirmed that the patient's privacy had not been maintained. The staff member revealed that there were two other rooms available on the ward when the patient was admitted and could not explain why the patient was placed in room #8 with no curtain for privacy. The staff member stated she was going to move the patient to another room.	A 143		
(A 144)	482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by:	(A 144)		

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(A 144)	Continued From page 5 Based on open record review, observation, staff and physician interview and hospital policy review, the hospital failed to maintain a safe environment by placing a patient in an environment that was not free of hazards for 1 of 14 current patients sampled (#3) and failed to ensure body alarms were worn by staff on duty according to policy for 3 of 3 staff members (Staff #3, 4 and 5) and 3 of 7 staff members (Staff #2, 6 and 7) assigned to two Adult Admissions Unit (AAU) wards (wards 382 and 233). Findings include: A) Failed to maintain a safe environment by placing a patient in an environment that was not free of hazards 1. Open record review on 03/13/2008 of Patient #3 revealed a 48 year-old male that was admitted to Room 6, ward 233, Adult Admissions Unit (AAU) on 03/02/2008 with a diagnosis of bipolar disorder. The review revealed the patient was petitioned for involuntary commitment for being a danger to self after he was found running through a residential neighborhood naked. Review of the physician's admission orders dated 03/02/2008 revealed an order for assault precautions. Further review of the physician's orders revealed an order dated 03/06/2008 at 1514 to discontinue assault precautions. Review of the nursing notes dated 03/06/2008 at 1800 revealed the "Patient was allowed to go to the courtyard for fresh air and started picking up cigarette butts off the ground to smoke. Staff told him he could not do that and he started cursing and swinging at staff once back on ward." Review of the record revealed the patient was manually restrained to escort him to the quiet room where he was placed in mechanical restraints from 1820 through 1935	(A 144)		

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(A 144)	Continued From page 6 Further review of the nursing notes revealed a note written by Staff #1 dated 02/08/2008 (date documented in error, should be 03/06/2008) at 2305 that documented "Patient asked to change room because patient had broken window frame out. Patient removed screen and broke frame into peices. Patient became upset, threatened to poke staff eye out if anyone touch him. Staff searched room and found window screen and broken window frame. Put patient in different room and locked door. Supervisor notified of situation." Observation during tour on 03/13/2008 at 1555 of room #6, ward 233, AAU revealed a patient room with two beds. There was a window that measured 72 inches wide by approximately 60 inches long that was located on an exterior wall on ground level. The window was separated into four sections with the bottom section containing a paneled window with a lever that opened the window pane to the outside. This window pane was approximately 24 inches long by 36 inches wide. This window pane was covered with a metal frame insert that contained a wire mesh screen with a glass panel covering on the interior to inhibit the ability to open the window. Further observation revealed no window covering for privacy. Observation on 03/13/2008 at 1600 of room #7, ward 233, AAU revealed another patient room with two beds. There was a window on the exterior wall that was identical to the window in room #8. This window had brenk away curtains that were supported by an aluminum track that was 72 inches wide. The aluminum track was held in place by two screws that were mounted into the concrete wall approximately 12 inches	(A 144)		

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(A 144)	Continued From page 7	(A 144)		

from each end. Observation of the aluminum track revealed the track was able to be partially pulled away from the concrete wall with minimal effort.

Interview on 03/13/2008 at 1555 with Staff #1 revealed he was a health care technician that was working on 03/06/2008. The staff member stated he was doing 30 minute rounds and entered Patient #3's room (room #8). The staff member stated the patient was in the room and the staff member noticed the mattress was bulging and conducted a search. The staff member stated he found the aluminum track that holds the curtains "bent up about three times" under the mattress. The staff member stated that then he noticed the screen and window frame were removed and the window was partially opened. The staff member stated he located the screened window frame under the mattress. The staff member stated the patient was removed from the room (#8) and relocated to another room on the same ward. The staff member stated that room #8 was locked after the patient was moved. The staff member stated that he thought the patient had removed the curtain rod (aluminum track) and pried the metal frame off that contained the screen to prevent access to the window opening to the outside.

Interview on 03/13/2008 at 1615 with Staff #2 revealed she was the registered nurse that was in charge on 03/06/2008 when the incident occurred. The staff member stated that the incident occurred during change of shift and she was getting ready to give report to the oncoming shift when the incident was reported to her. The staff member stated that she did not evaluate the patient after the incident but knew that the

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(A 144)	Continued From page 8 evidence was removed from the room and secured and the patient was relocated to another room. The staff member revealed that room #8 was locked after the patient was relocated. The staff member revealed that the patient was moved to another room with the identical window arrangement as room #8. The staff member confirmed that the room that Patient #3 was moved to after the incident contained an aluminum track attached to the concrete wall identical to the one that the patient had removed in room #8. The interview revealed that no increased observation or precautions were implemented after the change of room. The interview confirmed that the patient was placed in an environment after the incident that was identical to the environment prior to the incident and that no increased precautions were implemented to ensure the safety of the patient or others Interview on 03/14/2008 at 1030 with plant operations staff revealed the all the exterior patient room windows in the AAU have the same set up as room #8 on ward 233. The interview revealed the screened window pane and frame were replaced in room #8 on the morning of 03/07/2008. The staff revealed that the window panes were triple layered glass and would only shatter if broken and would not have sharp edges. The staff demonstrated that the windows open out from the bottom creating an opening of about six inches. Interview with the technician that replaced the window frame after the incident revealed that he did not replace the aluminum track to hang the curtains. The staff member stated "I did not put the curtain rod back up. I was afraid he would pull it down again." The staff member stated that this was not the first time the	(A 144)		

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{A 144}	Continued From page 9 aluminum tracks had been pulled down and that they have had to replace them before Interview on 03/14/2008 at 1235 with administrative staff revealed administrative staff became aware of the incident on 03/07/2008 through a copy of shift report that was sent to the hospital's leadership. The interview revealed no further review of the incident was deemed necessary since the patient was relocated to another room and the room that the patient was in (#8) was secured. The interview revealed the concern was with the panel out, not with the rod. The plant operations director stated that the aluminum tracks (rods) have been removed by patients in the past, but he could not recall how often it occurred. The interview further revealed that the aluminum tracks had been replaced with a wood strip in 12 of the patient rooms in the AAU beginning in 2006. The interview revealed that this change to wood strips was based upon costs related to maintenance rather than safety issues. The interview revealed the aluminum track was not viewed as a safety issue and that it was viewed as more of a destructive issue. The interview further revealed that the new room that Patient #3 was moved into had the identical window arrangement as room #8. The interview confirmed that the room that Patient #3 was moved to after the incident contained an aluminum track attached to the concrete wall identical to the one that the patient had removed in room #8. The interview confirmed that the patient was placed in an environment after the incident that was identical to the environment prior to the incident and that no increased precautions were implemented to ensure safety. 2. Observation during tour of the Adult Admission	{A 144}		

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(A 144)	Continued From page 10 Unit Ward 232 on 3/12/2008 at 1545 revealed, the door to patient room 2 to be unlocked and open. Observation of adjacent room's (patient, conference, supply, medication, nourishment, housekeeping) doors to be closed and locked. Observation of room 2 revealed a bedframe, mattress and linen (no removable furniture) in the room. Further observation revealed a metal wheelchair footrest laying on the floor in open view of individual's who entered the room. Observation revealed multiple patients in the hallway outside of the room. Interview during tour of the AAU Ward 233 on 03/13/2008 at 1541 with administrative nursing management staff member revealed the doors to all rooms are locked when patients are attending group sessions on the ward. The interview revealed that room 2 was left open because the patient that occupied the room used a wheelchair. The interview revealed that patients other than the room occupant had access to the room while the door was open and unlocked. The interview revealed the staff was unaware the metal foot rest was laying on the floor. The interview revealed that the metal foot rest should have been secured for safety. Further interview revealed the ward had four patients identified on assault precautions during tour. Further interview revealed that the metal foot rest could potentially be used as a weapon by a patient on assault precautions. B) Failed to ensure body alarms were worn by staff on duty according to policy. Review of the hospital's "Body Alarms/Security Systems" policy effective February 2008 revealed "Purpose. To provide protection for patients and staff. Policy. Body alarms shall be worn at all	(A 144)		

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(A 144)	Continued From page 11 times while in any patient care area where the system has been installed. The body alarm may be worn on a waistband, belt or pocket." 1. Observation on 03/12/2008 at 1600 during tour of ward 362 (behavior stabilization unit), Adult admissions Unit (AAU) revealed three staff members present on the unit at the time of the tour. Interview during the tour with Staff #3 revealed the staff member was a registered nurse that was functioning as charge nurse of the unit. Interview with the nurse revealed that the ward has patients that have been identified as "high maintenance patients" that may have had episodes of aggression requiring increased staff to patient ratios and decreased environmental stimulation. The interview revealed Staff #3 did not have a body alarm on at the time of the interview. The staff member stated that she had "just arrived" and had not yet put the body alarm on. The interview revealed that there were six body alarms available and they were kept in a drawer at the nursing station. The staff member stated that all staff were supposed to get the alarms out of the drawer at the beginning of the shift and wear them during working hours. The interview revealed the staff member had reported for duty at 1500 (one hour prior to the tour). Interview with Staff #4 during the tour revealed the staff member was a health care technician that reported to work at 1500. The interview revealed that Staff #4 did not have a body alarm on at the time of the interview. The staff member stated that he had just arrived and had not yet obtained the body alarm from the drawer. Interview with Staff #5 during the tour revealed the staff member was a health care technician that reported to work at 1500. The interview revealed that Staff #5 did not have a body alarm	(A 144)		

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(A 144)	Continued From page 12 on at the time of the interview. The staff member stated that he had just arrived and had not had time to put the body alarm on. Interview on 03/14/2008 at 1425 with a nursing administrative staff member revealed there was no monitoring on the Behavioral Stabilization Unit (AAU ward 382) to ensure the policy for wearing body alarms was followed 2. Observation on 03/13/2008 at 1561 during tour of Adult Admissions Unit (AAU) Ward 233, revealed seven staff members present on the unit at the time of the tour. Interview during the tour with Staff #2 revealed the staff member was a registered nurse that was functioning as charge nurse of the unit. Interview with the nurse revealed that the ward does utilize the use of body alarms and does care for patients who have been placed on assault precautions. The interview revealed Staff #2 did not have a body alarm on at the time of the interview. Interview with Staff #6 during the tour revealed the staff member was a health care technician. The interview revealed that Staff #6 did not have a body alarm on at the time of the interview. The staff member stated that he had taken his body alarm off and placed on the desk in the nurse's station. Interview with Staff #7 during the tour revealed the staff member was a registered nurse that was functioning as the medication nurse of the unit. The interview revealed that Staff #7 did not have a body alarm on at the time of the interview. The staff member stated that she had left her body alarm in the medication room. During the tour Staff #7 was observed to enter the medication room and returned with her body alarm attached to her waistband.	(A 144)		

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(A 144)	Continued From page 13 Interview during tour of AAU Ward 233 on 03/13/2008 at 1541 with a administrative nursing supervisor revealed that all staff members are to wear body alarms when on the ward with patients. Further interview revealed the staff failed to follow policy regarding the use of body alarms.	(A 144)		
A 267	482.21(a)(2) QAPI QUALITY INDICATORS The hospital must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that assess processes of care, hospital services and operations. This STANDARD is not met as evidenced by: Based on review of facility policies and procedures, corrective action plans, performance improvement data and staff interview facility leadership staff failed to monitor: A. staff use of body alarms and B. completion of temperature logs for medication and laboratory specimen refrigerators. Findings include: Review of the facility's Performance Improvement Plan for 2007-2008 revealed "IV. Quality Philosophy and Framework . C. Performance Improvement Approach - (name of facility)'s official Performance Improvement Model is the CARE Cycle. This process guides all performance improvement activities employed at (name of facility)...This process involves a systematic approach that must be applied to all formal problem-solving, performance	A 267		1/28/08

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A 267	Continued From page 14 improvement or process-design activities. C - Consider (Plan) involves considering what things are going wrong. A - Act (Do) involves reviewing all data collected and determining trends. R Review (Check) involves reviewing the changes that were made based on the data collection during the process E - Engage (Act) involves engaging to implement the changes on a full scale basis." A facilty leadership staff failed to monitor staff use of body alarms Review of the hospital's "Body Alarms/Security Systems" policy effective February 2008 revealed "Purpose To provide protection for patients and staff Policy' Body alarms shall be worn at all times while in any patent care area where the system has been installed The body alarm may be worn on a waistband, belt or pocket." Review of the facility's "Plan of Correction" revised 02-12-2008 revealed "2. Body Alarms Monitoring: Unit Nurse Directors, Shift Supervisors and Charge Nurses will monitor nursing staff on the wards to ensure the need to wear body alarms." Review of facility Performance Improvement data revealed no monitoring of staff use of body alarms. Observation during tour of the Behavioral Stabilization Unit 382 on 03-12-2008 at 1545 revealed one Registered Nurse (the charge nurse) and two Health Care Technicians on the unit with two patients present on the unit Observation revealed one HCT staff within 15 feet of and observing one of the patients in the day	A 267		

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A 267	Continued From page 15 room area of the unit. Observation revealed none of the three staff were wearing body alarms. Further observation revealed six body alarms were available for use in the nurses' station. Interview with administrative nursing staff on 3-14-2008 at 1425 revealed addressing body alarms was considered a performance improvement priority for the facility for patient and staff safety. Interview revealed it is the expectation that staff will wear body alarms when they arrive at their post. Interview revealed the staff members of the Unit 382 did not follow facility policy on wearing body alarms. Interview confirmed there was no data collected regarding use of body alarms for the facility's Rehabilitation Units to include the Behavioral Stabilization Unit 382. Interview confirmed the facility's leadership staff failed to follow the CARE process of performance improvement as outlined in the Performance Improvement Plan. Interview confirmed the facility's leadership staff failed to monitor for improvement in the area of staff use of body alarms as outlined in the Plan of Correction. B. facility leadership staff failed to monitor completion of temperature logs for medication and laboratory specimen refrigerators Review of the facility's "Plan of Correction" revised 02-12-2008 revealed "Patient nourishment storage/Refrigerator temperatures. Monitoring: Nursing shift supervisors will audit to ensure that...temperatures are checked nightly." 1. Observation during tour of the dirty utility room located outside of AAU Ward 232 (in the hallway	A 267		

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A 267	Continued From page 16 next to elevator #13) on 3/12/2008 at 1630 revealed a refrigerator labeled "biohazard" utilized for specimen storage. Further observation revealed a "Refrigerator & Freezer Thermometer Reading (Check/Record Daily)" form attached to the top of the refrigerator. Further review of the form revealed a line next to "Unit/ward" (left blank) and a line next to "Period Covered" left blank. Further review of the form revealed no temperatures recorded for the refrigerator for 2/1/2008, 2/11/2008, 3/4/2008, 3/7/2008, 3/11/2008, and no temperatures recorded for the freezer from 2/1/2008 thru 3/12/2008 (41 days). 2. Observation during tour of the Children's Psychiatric Unit Ward 532 on 3/13/2008 at 1440 revealed a refrigerator used for nourishment storage. Further observation revealed a "Refrigerator & Freezer Thermometer Reading (Check/Record Daily)" form attached to the outside of the refrigerator door. Further review of the form revealed "Period Covered"with "March 08 (hand written on a line)." Further observation revealed no temperatures recorded for the refrigerator for 3/1/2008, 3/2/2008, 3/7/2008, 3/8/2008, and no temperatures recorded for the freezer for 3/1/2008, 3/6/2008, 3/8/2008, and 3/9/2008. 3. Observation during tour of the Adult Admission Unit (AAU) Ward 232 on 3/12/2008 at 1546 revealed a refrigerator utilized for medication storage. Further observation revealed a "Refrigerator & Freezer Thermometer Reading (Check/Record Daily)" form attached to the outside of the refrigerator door. Further review revealed no temperatures recorded for the refrigerator or freezer for 3/5/2008.	A 267		

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A 267	Continued From page 17 Interview with administrative nursing staff on 3-14-2008 at 1425 revealed addressing completion of logs for refrigerator temperatures was considered a performance improvement priority. Interview revealed it is the expectation that staff complete the refrigerator logs at night. Interview revealed the supervisors failed to include the laboratory refrigerator on their data collection tool. Interview confirmed there had been no data collection regarding monitoring of the temperatures for the laboratory refrigerator used for storage of patient specimens. Further interview revealed the February 2008 data from the Adult Admissions Unit revealed the compliance with refrigerator logs was 100% Interview revealed the administrative staff was unsure as to the validity of the monitoring information. Interview confirmed the facility's leadership staff failed to follow the CARE process of performance improvement as outlined in the Performance Improvement Plan. Interview confirmed the facility's leadership staff failed to monitor for improvement in the area of completing refrigerator temperature logs as outlined in the Plan of Correction	A 267		
(A 395)	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by Based on open medical record reviews and staff interview the nursing staff failed to follow physician orders to meet the needs of the patients	(A 395)		

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(A 395)	Continued From page 18 in 2 of 14 current patients reviewed (# 8, #9). The findings include 1. Medical record review of Patient # 8 revealed a 33 year old patient admitted on 3-1-08 for anxiety and pneumonia. Review of the record revealed on 3-6-08 at 2308, the physician ordered the patient to have pulse oximetry (measures the amount of oxygen in the blood) done every 4 hours with vital signs and to notify the physician if pulse oximetry (pulse ox) was equal to or less than 88 %. Record review revealed the first pulse ox was completed at 2330. Record review revealed no documentation of a pulse ox completed at 1130 on 3-7-08 (scheduled due time). Record review revealed no documentation of why the patient did not have the pulse ox done. Record review revealed no documentation of the physician being notified that the pulse ox was not completed as ordered Interview with the assistant director of nursing on 3-13-08 at 1145 revealed there was no documentation of a pulse ox being completed at 1130 on 3-7-08. The interview confirmed the pulse ox was due at 1130. The interview revealed there was no documentation available of why the patient did not receive the pulse ox as ordered 2. Medical record review of Patient # 8 revealed a 33 year old patient admitted on 3-1-08 for anxiety and pneumonia. Review of the record revealed on 3-5-08 at 1922 the physician ordered the patient's temperature be rechecked in 30 minutes and to call the physician. Record review revealed the patient's temperature was rechecked at 1955. Record review revealed the temperature	(A 395)		

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(A 395)	Continued From page 19 was 103.6. Record review revealed the physician was not notified until 2016 (21 minutes after the temperature was rechecked) Interview with the assistant director of nursing on 3-13-08 at 1145 revealed there was no further documentation for the record. The interview revealed there was no documentation of why the staff did not call the physician per the order. 3. Open medical record review of patient #9 revealed a 61 year old patient admitted on 01/24/2008 with a diagnosis of schizoaffective disorder and moderate nutritional risk with poor oral intake. Review of physician's order on 02/26/08 at 1300 revealed a order for Ensure 360 milliliters by Nasogastric tube (tube for feeding) four times a day. Further review of physician's orders on 02/26/08 at 1300 revealed an order to weigh patient weekly and record. Review of healthcare technician flowsheet and vital signs/weight flowsheet revealed no documentation of weight on 2/26/08 (date weekly weight ordered). Further review of healthcare technician flowsheet revealed documentation of weight on 03/05/08 (8 days after physician order for weekly weight) Interview with administrative nursing staff on 03/14/08 at 1400 revealed weight should have been scheduled the next morning after order written. Further interview revealed the weight should have been done on 02/27/08. Interview confirmed there was no documentation of weekly weight on 02/26/08 or 02/27/08.	(A 395)		
(A 404)	482.23(c) ADMINISTRATION OF DRUGS	(A 404)		

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(A 404)	Continued From page 20 Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient's care as specified under §482.12(c), and accepted standards of practice This STANDARD is not met as evidenced by Based on hospital parameters for vital signs review, medical record review and staff interview the nursing staff failed to administer medication per the physician's orders in 1 of 14 open records reviewed (# 8) The findings include: Review of the "Addendum to Vital Procedure Parameters for Vital Signs" revealed "Nursing service employees will follow the vital sign parameters listed below Adults Temperature Auxiliary 96.8 - 98.6 Oral 97.5 - 99.6 Rectal 98.6 - 100.6 " Medical record review of Patient # 8 revealed a 33 year old patient admitted on 3-1-08 for anxiety and pneumonia. Review of the record revealed on 3-1-08 at 1930, the physician ordered Acetaminophen (medication to reduce fever) 650 milligrams by mouth every 4 hours as needed for pain/fever. Record review revealed on 3-6-08 at 0800 the patient's temperature was documented at 101.9. Record review revealed no documentation of administration of	(A 404)		

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(A 404)	Continued From page 21 Acetaminophen. Further review revealed documentation on 3-8-08 at 0630 and 0815 the patient's temperature was 101.6 and 101.5 respectively. Record review revealed no documentation of Acetaminophen administration from 0500 until 1300 on 3-8-08. Record review did not reveal why the patient was not administered Acetaminophen for the increased temperatures on 3-6-08 and 3-8-08 (2 times). Interview with the assistant director of nursing on 3-13-08 at 1145 confirmed the nursing staff did not administer Acetaminophen per the physician's order for the patient's fever.	(A 404)		
(A 700)	482.41 PHYSICAL ENVIRONMENT The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community. This CONDITION is not met as evidenced by: Based on observations, tours of the hospital, staff interviews and policy and procedure reviews as referenced in the Life Safety survey completed 12/20/2007, the hospital failed to arrange and maintain the facilities ensuring the safety of patients. The findings include: 1. The hospital failed to maintain the environment ensuring the safety and well being of patients as referenced in the Life Safety survey completed	(A 700)		

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(A 700)	Continued From page 22 12/20/2007. -Cross-refer to 482.41(a) Physical Environment Standard Tag A 701. 2 The hospital failed to ensure: exp red supplies were not available for patient use, supplies and patient nourishments were stored appropriately, refrigerator temperatures were monitored, terminal cleaning was performed upon patient discharge and quality linen was available for patient use -Cross-refer to 482.41(c)(2), Physical Environment Standard Tag A 724.	(A 700)		
(A 701)	482.41(a) MAINTENANCE OF PHYSICAL PLANT The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured This STANDARD is not met as evidenced by Continued non-compliance as evidenced by observations and staff interviews referenced in the Life Safety survey completed 12/20/2007, the hospital failed to maintain the environment ensuring the safety and well being of patients. The findings include 1. During tour of Building 2 on 12/19/07, the west	(A 701)		

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(A 701)	Continued From page 23 exit door Ward 238 and east exit door Ward 239 were observed having a hair pin or broken key in the door hardware (inability to unlock doors in case of emergency). (Corrected on Site) - Cross refer to Life Safety Code Standard - NFPA 101, Tag K 0038 2 Based on observation during tours of Buildings 8, 9, 10, 12, 13, 18, 19, 22, 23, 24 on 12/19/07, the means of egress was not paved to a public way - Cross refer to Life Safety Code Standard - NFPA 101, Tag K 0038. 3. (a) Observation during tours on 12/19/07 of Buildings 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13 and 14 revealed, the facility was using the corridor as a return air plenum. (b) Observation during tours on 12/20/07 of Buildings 15, 16, 17, 18, 19, 20, 21, 22, 23 and 24 revealed, the facility was using the corridor as a return air plenum Note: If a waiver is requested, the provider must certify that the following conditions are met: (1) Air handling units must be equipped with smoke detectors. (2) There must be a complete corridor smoke detection system. (3) Smoke detectors must be wired to the fire alarm system. (4) Fire alarm system must shut down all air handling units when activated - Cross refer to Life Safety Code Standard - NFPA 101, Tag K 0067. 4. (a) Based on observation of Building 3 on 12/19/07 the Records Room #29 (30ft x 30ft),	(A 701)		

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(A 701)	Continued From page 24 Ward 291, was not sprinkled nor separated (b) Observation during tour of Building 7 on 12/19/07 there was storage in room #13 (Ward 334). Room #13 was not sprinkled or separated with a 3/4 hour door. (c) The central supply room #462, Building 17 was greater than 100 sq ft. and is currently not protected with a one hour separation or sprinklered (d) Based on observation on 12/20/07 Building 20 room 19 is used as storage and is not one hour protected or sprinklered. (e) Based on observation on 12/20/07 Building 23 Ward 531 is used as storage and not sprinkled or one hour protected. (f) Based on observation on 12/19/07 Building 3, Room 8, Ward 291, was labeled as a conference room but was used as storage/medical records. Currently the door to the room is not a 3/4 hour door – Cross refer to Life Safety Code Standard - NFPA 101, Tag K 0029	(A 701)		
(A 724)	482.41(c)(2) FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE Facilities, supplies and equipment must be maintained to ensure an acceptable level of safety and quality. This STANDARD is not met as evidenced by:	(A 724)		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHN UMSTEAD HOSP	1003 12TH ST BUTNER, NC 27509

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(A 724)	Continued From page 25 Based on hospital policy review, observation during tours and administrative staff interviews the hospital failed to ensure: A) patient nourishments were stored appropriately for 2 of 11 units toured. B) refrigerator temperatures were monitored for 3 of 11 units toured. The findings included A) patient nourishments were stored appropriately. Review of facility policy "Subject: Nutrition Services Infection Control HACCP (Hazard Analysis Critical Control Point) Guidelines" effective September 2006 revealed, "C. FOOD HANDLING AND STORAGE . . 2. Storage. k. All leftovers are labeled, dated and discarded within two days. m. Products will not be used beyond expiration date." Review of facility policy "Subject: ICC. NOURISHMENTS" effective date 5/1/2004 revealed, "Procedures. Supplements/nourishments are prepared and issued in accordance with computer generated labels. Labels consist of the patient name, ward, date and/or time to be administered and type of supplements/nourishments ..." 1. Observation during tour of the patient nourishment refrigerator on the Children's Psychiatric Unit Ward 532 on 3/13/2008 at 1440 revealed the following food items that were not labeled with the patient's name (if applicable), dates and times. 12- Styrofoam cups of sliced fruit (oranges) and the following food items that had a manufacturers expiration date of 2/28/2008. 3 - (brand name) cups of chocolate pudding	(A 724)		

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(A 724)	Continued From page 26 Interview with the director of Unit 532 during tour on 3/13/2008 at 1407 revealed all food items in the patient nourishment refrigerator should be labeled with the appropriate patient's name (if applicable), date and time. Interview revealed that dietary staff should have removed the expired cups of pudding from the nourishment refrigerator. Interview revealed the unit director was unsure how long the food items had been in the refrigerator. Interview revealed the food items were available for patients to eat. 2. Observation during tour of the patient nourishment refrigerator on the Children's Psychiatric Unit Ward 494 on 3/13/2008 at 1407 revealed the following food items that were not labeled with patient's name (if applicable), dates and times. 5 - four (4) ounce plastic containers of diced peaches. Interview with the director of Unit 494 during tour on 3/13/2008 at 1407 revealed all food items in the patient nourishment refrigerator should be labeled with the appropriate patient's name (if applicable), date and time. Interview revealed the unit director was unsure how long the food items had been in the refrigerator. Interview revealed the food items were available for patients to eat. B) refrigerator temperatures were monitored Review of facility policy "Subject: Nutrition Services Infection Control HACCP (Hazard Analysis Critical Control Point) Guidelines" effective September 2006 revealed, "C. FOOD HANDLING AND STORAGE 2. Storage... f. Refrigerator and freezer temperatures must be monitored and recorded daily to assure that the appropriate temperatures are maintained..."	(A 724)		

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(A 724)	Continued From page 27 1 Observation during tour of the dirty utility room located outside of AAU Ward 232 (in the hallway next to elevator #13) on 3/12/2008 at 1630 revealed a refrigerator labeled "b-ohazard" utilized for specimen storage. Further observation revealed a "Refrigerator & Freezer Thermometer Reading (Check/Record Daily)" form attached to the top of the refrigerator. Further review of the form revealed a line next to "Unit/ward" (left blank) and a line next to "Period Covered" left blank. Further review of the form revealed no temperatures recorded for the refrigerator for 2/1/2008, 2/11/2008, 3/4/2008, 3/7/2008, 3/11/2008, and no temperatures recorded for the freezer from 2/1/2008 thru 3/12/2008 (41 days). Interview during tour with administrative management staff on 3/12/2008 at 1630 revealed that refrigerator and freezer temperatures are to be checked and recorded daily on the temperature log for refrigerators used to store laboratory specimens. The interview confirmed the hospital staff failed to record temperatures for the refrigerator for 2/1/2008, 2/11/2008, 3/4/2008, 3/7/2008, 3/11/2008, and for the freezer from 2/1/2008 thru 3/12/2008 (41 days). Further interview confirmed the hospital staff failed to follow policy regarding refrigerator temperature checks. 2 Observation during tour of the Children's Psychiatric Unit Ward 532 on 3/13/2008 at 1440 revealed a refrigerator used for nourishment storage. Further observation revealed a "Refrigerator & Freezer Thermometer Reading (Check/Record Daily)" form attached to the outside of the refrigerator door. Further review of the form revealed "Period Covered" with "March	(A 724)		

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(A 724)	Continued From page 28 08 (hand written on a line)." Further observation revealed no temperatures recorded for the refrigerator for 3/1/2008, 3/2/2008, 3/7/2008, 3/8/2008, and no temperatures recorded for the freezer for 3/1/2008, 3/5/2008, 3/8/2008, and 3/9/2008. Interview during tour with the unit director on 3/14/2008 at 1435 revealed that refrigerator and freezer temperatures are to be checked and recorded daily on the temperature log for refrigerators used to store nourishments. Further interview confirmed the hospital nursing staff failed to record temperatures for the refrigerator for 3/1/2008, 3/2/2008, 3/7/2008, 3/8/2008, and for the freezer for 3/1/2008, 3/5/2008, 3/8/2008, and 3/9/2008. Further interview confirmed the hospital staff failed to follow policy regarding refrigerator temperature checks. 3. Observation during tour of the Adult Admission Unit (AAU) Ward 232 on 3/12/2008 at 1546 revealed a refrigerator utilized for medication storage. Further observation revealed a "Refrigerator & Freezer Thermometer Reading (Check/Record Daily)" form attached to the outside of the refrigerator door. Further review revealed no temperatures recorded for the refrigerator or freezer for 3/5/2008. Interview during tour with the unit director on 3/12/2008 at 1546 revealed that refrigerator and freezer temperatures are to be checked and recorded daily on the temperature log for refrigerators used to store medications. The interview revealed it is the responsibility of the nursing staff to check and record the temperatures daily. Further interview revealed the temperatures are usually checked and	(A 724)		

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(A 724)	Continued From page 29 recorded on third shift. The interview confirmed the nursing staff failed to record a refrigerator and freezer temperature for the medication refrigerator on 3/5/2008. Further interview confirmed the hospital staff failed to follow policy regarding refrigerator temperature checks.	(A 724)		